PROTECTIVE INSURANCE COMPANY
Work Accident Claims Department
111 Congressional Blvd., Suite 500
Carmel, Indiana 46032
1-800-231-6024

INDEPENDENT CONTRACTOR ACCIDENT INSURANCE

PROOF OF CONTINUOUS DISABILITY

Instructions: To continue to receive benefits complete and mail this form to Protective within 20 days of receipt by our. Failure to do so shall be reason to terminate our benefits.

1. Insured Person's Name and Mailing Address (No. Street, City, County, State, Zip)	2. Phone ( )	3. Social Sec. No - -	4. DO NOT COMPLETE THIS PART Sponsor
5. Terminal Address and Number, if applicable (No., Street, City, County, State, Zip)	6. Last DOT Physical Date / / (Month, Day, Year)	7. Birthday / / (Month, Day, Year)	
	8. Are you still disabled due to a work accident? (Circle one) Yes No	9. Have you returned to any type of full-time work activities? (Circle one) Yes No	

10. Have you returned to any type of part-time work activities? (Circle one) Yes No	11. Date you returned to any type of work activities / / (Month, Day, Year)	12. If you have returned to work activities are you now self-employed? Yes No (Circle one) If no, indicate name, address, phone number of your current employer or the person or firm for which you are now working.
13. Are you under the regular care of a doctor? (Circle one) Yes No	14. Indicate Name, Address and Phone Number of Treating Doctor (No., Street, City, State, Zip)	

15. Describe in detail your current physical condition, indicating the part of the body (Spine, Ankle, Arm, etc.) causing disability and your physical limitations. (i.e. unable to lift, walk, etc.)

16. List other companies with which you are insured and benefits you expect to claim as a result of your accident.

	Company	Policy	Policy Date	Amount of benefit (State Weekly or Monthly)
1.				
2.				
3.				

17. Are you receiving, have you filed for, or do you intend to file for Social Security Benefits? (Circle one) Yes No	18. Are you receiving, have you filed for, or do you intend to file for No-Fault Benefits? (Circle one) Yes No	19. Are you receiving, have you filed for, or do you intend to file for Unemployment Benefits? (Circle one) Yes No	20. Are you receiving, have you filed for, or do you intend to file for Workers' Compensation Benefits? (Circle one) Yes No
Amount _____	Amount _____	Amount _____	Amount _____
Effective Date _____	Effective Date _____	Effective Date _____	Effective Date _____

PLEASE READ CAREFULLY BEFORE SIGNING THIS PROOF!

I UNDERSTAND the information on this proof will be included as part of my claim and will be used by Protective Insurance Company to determine my continuing eligibility for Independent Contractor Accident Insurance Benefits. The information obtained may be disclosed to any reinsuring company, fraud or overinsurance detection bureaus, or to any person or organization performing business, medical or legal functions for Protective Insurance Company. The information obtained may be disclosed to other persons or organizations, if required by law, or as I many further authorize.

I CERTIFY that I have previously authorized any doctor, medical practitioner, hospital clinic, or other medical facility having information available regarding my injury and/or disability, diagnosis, treatment and medical history regarding the accident listed above to give to Protective Insurance Company or their legal representatives any and all such information.

I CERTIFY that I am an independent contractor in the trucking industry, not an employee of the Sponsor nor of one under contract to the Sponsor, and I am not eligible for Workers' Compensation benefits.

I CERTIFY to the correctness of the above statements and information on this proof and agree to notify Protective Insurance Company promptly of any changes or when I return to work activities. Failure on my part to correctly answer the questions above or failure on my part to notify Protective on my return to work activities shall cause all my benefits to be terminated.

I UNDERSTAND that completion and return of this form is a policy requirement and any delay in return or failure to return properly completed may caused an interruption or termination of benefits otherwise due under the policy.

_____
Signature Date

ID: 10306

PROOF OF CONTINUOUS DISABILITY

This proof is furnished to aid you in your receipt of Continuing Disability Benefits. Please be certain to answer every question.

Failure to promptly return this Proof shall result in delay or termination of benefits to which you may otherwise be entitled.

Please return to:

PROTECTIVE INSURANCE

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ID: 10306